Revised August 25, 2005

Summary of the Meeting of the CON Task Force

August 11, 2005

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Task Force Members Present

Commissioner Robert E. Nicolay, CPA, Chairman
Commissioner Larry Ginsburg
Alan Bedrick, M.D.
Albert L. Blumberg, M.D., F.A.C.R.
Lynn Bonde
Patricia M.C. Brown, Esquire
Annice Cody
Hal Cohen, Ph.D.
Natalie Holland
Carlessia A. Hussein, DrPH
Adam Kane, Esquire
Lawrence Pinkner, M.D.
Joel Suldan, Esquire
Christine M. Stefanides, RN, CHE
Douglas H. Wilson, Ph.D.
Elizabeth Weglein

Task Force Members Absent

Commissioner Robert E. Moffit, Ph.D.
William L. Chester, M.D.
Michelle Mahan
Henry Meilman, M.D.
Anil K. Narang, D.O.
Frank Pommett, Jr.
Barry F. Rosen, Esquire
Jack Tranter, Esquire

Members of the Public Present

Erwin E. Abrams, Hospice Network of Maryland
Robert Ascher, Jewish Family Services
Clarence Brewton, MedStar Health
Regina Bodnar, Hospice of Baltimore
Amy Broderick, Hospice Network of Maryland
Nancy Creighton, St. Agnes HealthCare
Sean Flanagan, St. Joseph Medical Center
Valerie Fox, Stella Maris
Shelley Garfield
Peg Green, HomeCall Hospice
Margaret Hadley, Holy Cross Hospital

Elton Hankins, Coastal Hospital, Inc.
Marie Harkova, Shore Home Care Hospice
Wynee Hawk, Greater Baltimore Medical Center
Katherine Hax, Kaiser Permanente
Kevin Ireland, Coastal Hospice
Deron Johnson, Maryland Ambulatory Surgical Association
Anne Langley, Johns Hopkins Health System
Michael McHale, Community Hospices
Denise Matricciani, MHA: Association of Maryland Hospitals & Health Systems
Ann Mitchell, Montgomery Hospice
Frank Monius, MHA: Association of Maryland Hospitals & Health Systems
Vanessa Purnell, MedStar Health
Barbara Ray, Hospice Caring
Laura Resh, Carroll Hospital Center
Joyce Sexton, JSSA Hospice
Maryanne Shiply, Capital Hospice
Stephanie Smith, Heartland Hospice
Olivia Stewart, Jack Neil & Associates
Gail Thompson, Kaiser Permanente

1. Call to Order

Chairman Robert E. Nicolay called the meeting to order at 1:05 p.m. and welcomed Task Force members and the public. He introduced a new Task Force member, Elizabeth Weglein, who replaced Terri Twilley, MS, RN as a representative of home health agency providers.

2. Approval of the Previous Minutes (June 23, 2005, revised and July 11, 2005)

Chairman Nicolay noted that the Task Force members had received copies of the revised June 23rd and the July 14th minutes and asked for any comments, changes, or corrections. Dr. Albert Blumberg made a motion to approve the revised June 23, 2005 minutes, which was seconded by Dr. Lawrence Pinkner, and unanimously approved. Annice Cody requested that the July 14th minutes be revised to reflect her vote in favor of retaining Certificate of Need for home health agency services, and Dr. Blumberg requested revision of a quote attributed to him in paragraph 6 on page 11. Dr. Blumberg made a motion to approve the minutes, as amended, which was seconded by Dr. Pinkner, and unanimously approved.

3. Review and Discussion of the Public Comments Received on the CON Program

- **Recap of the July 14, 2005 Meeting**

Chairman Nicolay presented a recap of the July 14th meeting. He noted the excellent quality of the comments received regarding what the group believes should constitute the guiding principles of the Certificate of Need program, and recalled similarly thoughtful discussion on issues of Certificate of Need coverage of inpatient obstetric services, home health agency services, and for burn care services. Patricia M.C. Brown, representing The Johns Hopkins Health System, requested that the Task Force reconsider its preliminary recommendation to deregulate burn care services from Certificate of Need. Chairman Nicolay noted that Ms. Brown had promised to submit a position paper on this subject, prior to a re-consideration of the issue by the Task Force. Ms. Brown again expressed her concern about the nature and effect of votes taken by the Task Force on each of these coverage issues. Chairman Nicolay reiterated that these were only preliminary votes to gauge the sense of the group, and that the Task Force would have the opportunity to revisit these issues when it considers its draft report and recommendations to the full Commission.

- **Coverage by CON Review: Hospice Services**

Chairman Nicolay provided a summary of the Task Force's earlier hospice debate and of the additional information provided to the members, and indicated that he would ask the members to take a vote on this issue. Lynn Bonde noted for the record that the hospice community of Maryland was present in some force, with representatives of hospices from all over the state. Their presence reflected the concern of the hospice community on the work of this Task Force and the outcome of this particular discussion.

Chairman Nicolay thanked the hospice representatives for attending the meeting and listening to the debate. In response to Commissioner Larry Ginsburg's request for clarification on the nature of the Task Force's votes, the Chairman reiterated that all of the votes to date were preliminary in nature. Staff will draft a report and recommendations based on the deliberations of the Task Force, which will come to the group for its consideration. Once this document is final, it will be forwarded to the full Commission for consideration and action.

Ms. Bonde thanked the staff for preparing a comprehensive issue paper for the Task Force, and collecting data about hospice in Maryland and across the country. She emphasized that the current CON regulatory structure for hospice has produced enormous benefits for the people in Maryland, and suggested that those who would argue to eliminate that regulatory structure have not addressed the consequences to the people of this state. She expressed concern about the speculative nature of comments made during the previous Task Force discussion, to the effect that more competition in hospice – an unrestricted growth in the number of new agencies -- will produce either more hospice patients or better outcomes for hospice patients. Ms. Bonde cited anecdotal evidence, provided in a letter to the Task Force from Ann Mitchell of Montgomery Hospice, that hospices in states without CON struggle to provide care, struggle with one another, and have to divert patient care resources to competitive concerns.

Ms. Bonde observed that in Maryland, Certificate of Need does not bar entry into the hospice care market, but does control entry. The chart included in the staff's issue brief indicates that hospices have changed hands, new hospices have come into the market, and new CONs have been issued in accordance with the State Health Plan. While she found nothing particularly compelling in the argument to deregulate, there was something very compelling about the negative consequences to the existing hospices, but also, and most importantly, to patients and their families, if hospice care programs are deregulated from Certificate of Need coverage.

Dr. Blumberg explained that his comments in favor of deregulation during the earlier discussion did not specifically address coverage of hospice programs, as much as they reflected his inherent negative feeling about the way that the CON process is administered in general, and particularly about inconsistencies in the level and nature of regulatory requirements applicable to similar kinds of medical services. Following the group's previous discussion about hospice, and specifically as a result concerns expressed by Task Force member Adam Kane at that time about ensuring continuity of care for residents at Erickson retirement communities, Dr. Blumberg said that he spoke to a friend who serves as medical director of several area nursing homes, whose viewpoint Dr. Blumberg wanted to share with Task Force members. His physician friend is very much in favor of maintaining the hospice Certificate of Need, for several reasons: he believes that hospice is an important benefit to his patients, that sufficient programs exist to provide a range of choice to nursing home residents, and that he does not want to assume medical direction responsibilities for residents once they enter hospice care. Dr. Blumberg's friend wondered if the interest of some in entering this

market aimed at capturing the additional Medicare revenue that would result from admission of a nursing home resident to hospice care, and wondered whether receiving hospice care directly from the nursing home provider could mean that a resident would receive fewer services than those provided by an outside contractor.

Mr. Kane responded that he was aware of the "revenue stream" argument, and explained further his organization's interest in providing hospice services directly to the residents of Erickson-managed continuing care retirement communities. The average length of stay for a resident of Erickson communities—from independent living through assisted living through skilled nursing care -- is between seven and eight years. During that time, a resident has his or her entire range of health care needs managed and provided by a consistent set of professionals; people come to Erickson communities specifically to receive that integrated system of services, and the system works well. Erickson's data demonstrate that residents receiving this set of integrated services are much less likely to need nursing home- or hospital-level care. In addition, Erickson has also recently received approval to establish its own Medicare Advantage program, so not only does it provide housing, meals, and health care, but it now also bears the full risk, as a payer, on the health care outcomes of its residents. The only service in the continuum of care -- from independent living through home health, assisted living, and skilled nursing care – that Erickson cannot directly provide to its residents is hospice care. According to Mr. Kane, it is counterintuitive that state policy recognizes exceptions to the CON process for home health care and for skilled care for continuing care retirement communities, because there is a value to continuity of care to have the same caretakers for residents, but then, at the end of life, residents have to have a different provider of hospice care. Mr. Kane maintained that this does not serve the best interests of CCRC residents, and that Erickson was not seeking to provide a lesser level of services to its residents than an outside hospice does.

Mr. Kane added that Erickson has been working with the University of Maryland School of Nursing to develop an online hospice training program, which will train 100 students to provide hospice and palliative care. If the State Health Plan is not changed to allow CCRCs to seek Certificate of Need approval to provide hospice care to their own residents, many of these nurses employed by Erickson will have to seek employment elsewhere, in order to use this training. In general, he said, Maryland's use rate of hospice care is lower than the national average, and people are dying in hospitals and assisted living facilities without the benefits available from a hospice program. The fact that the State Health Plan standards for hospice services does not include the same kind of "specialty" designation that permits CCRCs to seek approval to provide home health agency services to their residents means that the Erickson-managed communities cannot provide this more integrated range of health care, with a continuity of caregivers.

In terms of CON in general for hospice, Mr. Kane said, he is unsure of the ultimate effect, except that Certificate of Need coverage seems to have kept for-profit hospices out of the state. If the most frequently-cited rationales for Certificate of Need regulation include the protection of state budget funds, especially Medicaid expenditures, avoid unnecessary capital costs, and promote higher volumes to ensure higher quality of care, Certificate of Need for hospice would not seem to achieve any of those goals. Hospice is overwhelmingly a Medicare-reimbursed health care service, and its home-based programs incur virtually no capital cost. The high volume-quality correlation is unclear in hospice care: as Ms. Bonde mentioned at an earlier meeting, hospice volumes in Maryland range from an annual census of 20 to one of 200 patients, but few would suggest that the program caring for ten patients is doing a poor job, while the one with 200 is giving better care. In his view, quality of care in a hospice program is likely to have a higher correlation to the experience and dedication of the caregivers.

In response to Dr. Blumberg's question about whether Erickson has ever applied for a CON for hospice, Mr. Kane replied that within the current regulatory structure there is no legal mechanism to allow Erickson to seek Certificate of Need approval to establish a hospice program that provides care only to CCRC subscribers, as there is for skilled nursing beds and home health agency services. Pamela Barclay, Deputy Director of Health Resources, confirmed this, adding that the Commission has under consideration a petition by Erickson communities to change the hospice chapter of the SHP that would permit CCRCs to seek Certificate of Need approval to establish such a "specialty" hospice program.

Mr. Kane said that Erickson-managed communities in Maryland have about 6,000 residents, of which forty receive hospice care at any given time. He stressed that for Erickson, it is not a financial issue, but part of its ethical and moral obligation to provide coordinated care to its residents. Dr. Blumberg asked if Erickson is barred legally from applying for a CON to establish a general hospice program. Ms. Barclay replied that Erickson could apply if there was need identified for a new hospice agency in the jurisdictions where its communities are located. The need projections, which the Commission is in the process of updating, do not currently identify need for additional hospice programs. In response to a question from Dr. Blumberg, Ms. Barclay said that the Commission has not analyzed whether the State's nursing home residents represent an underserved population where hospice services area concerned.

Dr. Blumberg asked if there is anything in the law to preclude Erickson communities from buying an existing hospice, and adding it to the services that they provide. Ms. Barclay responded that acquisitions are not subject to CON review. Hal Cohen noted that Erickson does not want to do general hospice—only hospice for its own patients. Ms. Brown asked if a proposed "specialty" hospice program, to serve only a specific CCRC, would be subject to the Plan's projection of need. Ms. Barclay explained that, similar to the specialty home health agency available to a CCRC applicant, a prospective CCRC specialty hospice would be required to support its proposed program by showing sufficient volume, staff, and financial resources, but would not be precluded from applying if no need were projected for new programs in the State Health Plan. In contrast, Commission statute and regulations provide that CCRCs may establish – outside of the Certificate of Need process – a skilled nursing facility for its subscribers, with a number of beds based on a percentage of the communities' independent living units. Task Force member Douglas H. Wilson, Ph.D. asked if there has been interest on the part of other Maryland nursing homes to establish hospice programs; Ms. Barclay replied that, to her knowledge, no individual nursing homes have raised this issue.

In response to Ms. Bonde's question about how Erickson is currently providing hospice care to its forty patients, and the quality of that care, Mr. Kane said that Erickson contracts with a variety of existing hospice providers, who are doing a good job. He emphasized that Erickson's elderly residents desperately need integrated health care, and that hospice services are the only service that its communities cannot provide directly.

Ms. Bonde asked if Erickson's residents have requested that Erickson provide hospice care. Mr. Kane responded that he did not know, but that residents' councils at one or two of Erickson's communities had written in support of its request to change the State Health Plan. Mr. Kane added that, even if it were to become a hospice provider to its subscribers, they would still be free to choose other providers, and might do so based on religious affiliation, or on the preference of their physician. He said that Erickson simply wanted to give its residents the ability to maintain the integrity and continuity of their health care services in the event of a terminal diagnosis, to keep their same nurses (that Erickson is already training to give hospice and palliative care), the same pastoral staff and the same physicians, supported by their on-site electronic medical records.

Ms. Bonde suggested that Erickson's decision to establish a hospice agency represented a corporate decision, rather than one based on a stated desire of its residents to maintain their continuity of care. Mr. Kane replied that he viewed the matter differently, and that Erickson is trying to improve the quality of care and experience for its residents. He maintained that the negative reaction by the existing hospice community to Erickson's proposal to change the State Health Plan by creating the "specialty CCRC" category in hospice care has itself concerned the bottom line and corporate issues, and not focused on the impact of such a change on the quality and the continuity of care for CCRC residents.

Chairman Nicolay pointed out that the proposal for Plan change by Erickson was different from the question before the Task Force of whether to continue or end the coverage by Certificate of Need review of hospice programs, and noted that the Commission was in the process of addressing the Erickson State Health Plan proposal.

Alan Bedrick, M.D. expressed concern that the Task Force was moving along in similar fashion as the consideration of CON for obstetric services, where there was a tendency to focus on a particular institution or a particular stakeholder without necessarily looking at broad state interests. He cited the experience of South Carolina, cited by the Hospice Network, in which deregulation from Certificate of Need was followed by anecdotal reports of a deterioration in the kind and quality of hospice care. He asked if there was additional data from other states. Ms. Bonde replied that the national data from hospices is fairly scanty, although, based on the limited data that is available, hospices in CON states have higher numbers of visits by hospice staff to patients, and also higher overall spending on patient care per admission, than hospices in non-CON states.

Ms. Bonde stressed that hospices provide a fixed-price service, and that their only flexibility is in how much money the program chooses to spend on patient care. The single largest after-staff cost item in hospice care is for pharmaceuticals – largely pain medications -- for patients. Hospice providers who spend less of the fixed Medicare reimbursement for their patients do not serve their patients well: the programs are not as innovative, and do not spend as much money on pharmaceuticals and on alternate therapies. The concern is that if a hospice provider must compete for a limited pool of patients, the costs of increased competition, such as advertising, will consume the resources otherwise available for direct patient care.

Task Force member Carlessia A. Hussein, DrPH asked what the mechanism is for measuring quality in the hospice marketplace; Ms. Barclay replied that hospices in Maryland are licensed as either a limited or a general program, and receive State licensure as well as Medicare certification from the Office of Health Care Quality, in the Department of Health and Mental Hygiene.

Ms. Bonde noted that OHCQ staff is more overburdened than the Commission's staff, and that the benefit of Certificate of Need coverage of new hospice programs is that it only permits new providers into the market when and where increased need exists. She agreed with Mr. Kane that hospice use is low in nursing homes nationwide, and said that several factors may be responsible – including the differences in the hospice benefit for a nursing home resident and the facility's costs and charges. However, Maryland data shows a higher use of hospice care by minorities than in other states, and Maryland also has several hospices that provide pediatric care. She emphasized that the hospice providers meet the needs of the people of this state.

Dr. Hussein expressed concern about the potential for "punting the responsibility for quality to the licensure program, absent some factual information on its ability to accept it and carry it out." She

recalled that this suggestion has been proposed on several different occasions, and noted that she has scheduled a meeting with members of OHCQ staff to hear their views on the subject, since they have not been present to respond to the suggestion that OHCQ bear all of the responsibility for quality promotion and oversight. Dr. Hussein emphasized that it would only be acceptable to shift this entire responsibility from one agency to another if OHCQ can effectively handle their additional responsibility. Chairman Nicolay agreed that Dr. Hussein's comments must be a part of the Task Force's consideration. Elizabeth Weglein added, with respect to the current level of licensure and oversight for home health agencies currently regulated by OHCQ, that OHCQ can only review their performance, by survey, once every two years; OHCQ is not currently conducting on-site surveys of the other levels of home care providers it licenses, even though statute requires it to do so. She concluded that OHCQ does not have enough resources or staff to effectively meet its current oversight responsibilities.

Dr. Blumberg reiterated his previously-stated view that Certificate of Need cannot "ensure," but can "promote" quality of care. Quality oversight and enforcement is within the statutory authority of the State's licensure agency, once a project receives Certificate of Need approval and begins operation. If the licensure agency cannot perform these duties adequately, it might be appropriate for the Commission to bring that to the attention of other state officials, but it is not within the Commission's mandate to ensure quality in an ongoing fashion. He maintained that the job of the Commission in the Certificate of Need process is to establish a bar that one has to meet in order to allow a service or facility to be initiated, inaugurated, and moved forward. He suggested that the Task Force focus on one of its primary charges, defining the role of the Certificate of Need process. Dr. Hussein replied that in the sections of Commission statute related to the Certificate of Need program, promoting quality is one of its responsibilities, not simply cost and availability of services.

Ms. Cody expressed concern about not only the effect of complete deregulation of hospice services, but also the current need methodology, which has not allowed for growth in the number of hospice providers. She suggested that some middle ground should be identified between those two extremes. Other chapters of the SHP take the approach of permitting only one new program at a time, for example, or permit a proposed new program that may not be needed according to a formulaic need methodology to demonstrate the benefits to its community if its Certificate of Need application is nevertheless approved. She suggested, as an example, that the Plan could include a requirement for greater outreach to potential patients, with a goal of increasing the number of patients enrolled in hospice. Alternatively, Ms. Cody suggested including requirements related to demonstrating increases in quality of care, and requirements for more supportive services, in order to raise the overall benefit of hospice.

Dr. Cohen observed that he had commented at some length when the Task Force last discussed hospice, and he continues to believe that the rationale for (and benefits of) CON are largely related to capital investment, and therefore do not apply to hospice programs. He reiterated that if need is defined by the number of patients that hospices can serve, then there is, in theory at least, no limit to the capacity of an individual hospice program. An approved hospice can continue to grow depending upon how many people it hires. Dr. Cohen expressed concern about the hospice industry's assumption that more competition leads to lower quality, and suggested that one way to lower costs is for patients to be attracted earlier and more patients to be attracted into the industry. On balance, it was not clear to him that there is any reason to preclude a greater choice of providers from this market.

Chairman Nicolay noted that the purpose of the Task Force was to hear and consider both sides of these issues. Joel Suldan observed that providers spend a lot of money trying to enrich the patient experience in today's competitive environment, because their competitors are doing so. Consequently,

he expressed surprise at Ms. Bonde's comment that experience following deregulation from Certificate of Need in other states suggests that where there is more competition, there is less spending on patient care, which would be a compelling argument to retain Certificate of Need coverage if it were true. Mr. Suldan also disagreed with the argument that CON has ensured a stable market, citing the fact that over the past several years, this market has seen nineteen acquisitions, two mergers, and three closures, by his count, and that the acquisition or merger of a provider usually means that it is not doing well.

Chairman Nicolay asked if other members of the Task Force had something to add to the discussion. Ms. Brown again expressed concerns about the direction of the discussion, suggesting that she was not certain that the Task Force had received an adequate briefing and analysis on the underlying policy issues on this question, and on why new hospice programs, or expansions into new jurisdictions by existing hospices, require Certificate of Need approval. She said that the assumption seems to be that Maryland regulates hospice services through Certificate of Need in order to minimize the negative effects of competition on current providers.

Ms. Brown maintained that other policy reasons support maintaining Certificate of Need coverage of hospice, as well as of other health care services. She cited the possibility of "cherry-picking" by new, potentially for-profit entities, discussed in the Task Force's earlier discussion on the hospice issue, as one such reason. An unrestricted market could introduce new providers who are not interested in seeing Medicaid patients, for example; the State Health Plan currently addresses this access issue, with a Certificate of Need review standard requiring potential new providers to accept Medicaid as well as Medicare, and to agree to provide charity care. Those are the types of standards, as well as other quality-related requirements, that the Plan and this Commission adds to the competition argument, Ms. Brown said. She suggested that the Task Force to date seems to be considering solely arguments for or against increased competition in the health care market, and the rationale for the Certificate of Need program goes beyond that issue.

Natalie Holland said that there was a requirement that new hospice programs serve some level of Medicaid patients, and asked if Medicaid does in fact reimburse hospice care. Ms. Bonde responded that the Medical Assistance program does pay for hospice care, but that its share of total reimbursements was quite small. Ms. Barclay added that, in addition to its requirement that a new hospice be certified to receive reimbursement from both Medicare and Medicaid, there is a requirement in the Plan that programs provide charity care. Ms. Bonde explained that charity care is provided to patients who have neither Medicare, Medicaid, nor any private insurance, and that hospice providers care for those patients as well. The Maryland Medicaid program provides essentially the same hospice benefit for the single-eligible that Medicare covers for its recipients. The largest portion of Medicaid dollars for hospice is spent for those dually eligible for Medicare and Medicaid, in the form of room and board costs at nursing homes, for residents who are also in hospice care.

Ms. Brown observed that this fact illustrated that more reasons exist to continue Certificate of Need coverage of hospice programs than the group discussed earlier. Dr. Bedrick asked if there have been many applications for hospice. Ms. Barclay replied that there have not, adding that the Commission last conducted a comparative review for hospice a number of years ago, but had scheduled no recent reviews because the currently-effective State health Plan does not project need for new agencies in any jurisdiction. She noted that the Commission implemented a new system for collecting data two years ago, and is now updating its need projections based on that new data; this analysis will come to the Commission later this year. Dr. Bedrick asked if anything has precluded an applicant from applying for a CON. Ms. Barclay said that when the SHP projects need, that is basically an invitation to submit proposals to establish additional hospice capacity. When the Plan does not project need, the Commission does not solicit or accept new applications.

Dr. Blumberg suggested that Ms. Brown's questions and Ms. Bonde's comments merited the Task Force's reconsideration of the hospice issue. Dr. Blumberg added that his reading of the hospice section of the Commission's report on its 2000-2001 legislatively-mandated examination of the CON program suggested that Certificate of Need coverage of hospice programs went into effect sometime in the 1980's. He asked why Maryland imposed the requirement at that time, on a service not previously covered by Certificate of Need. Susan Panek of Commission staff clarified this history, explaining that the Certificate of Need requirement actually dates back to the 1970s, but generally applied to inpatient facilities modeled after those advocated by Dr. Elizabeth Kubler-Ross and the early hospice movement. The Joseph Richey House in Baltimore received Con approval during this period. The change in hospice regulation in the 1980s was a clarification and expansion of State licensure statute, which explicitly required hospice programs to obtain a license, whether they provided care at an inpatient facility or in the home or another kind of residence.

Ms. Brown observed that, as a matter of policy, the Task Force should assume that the concerns expressed by the existing hospice providers – about cherry-picking and the impact of a potential increase in the number of providers to intensify staffing problems caused by the current shortage of nurses and other direct care staff – are also challenges facing home health agencies, with implications for continuing Certificate of Need coverage of that service. Ms. Brown stated that the State Health Plan CON review standards address the availability of nurses and other key staff, for purposes of reviewing an application to establish a new hospice or home health agency, and asked if any other review process, by OHCQ or any other agency, would address that issue, if Certificate of Need coverage were eliminated. Ms. Barclay responded that licensing's perspective on staffing issues is different; OHCQ looks at staffing with respect to care provided to individual patients, quite a different issue from the availability of sufficient staff in the community to support existing programs, or additional ones.

Ms. Bonde said that in addition to issues related to the overall supply of nurses, hospice faces an additional, unique challenge, in that not every nurse who comes out of the community college nursing program inclined or even able to choose hospice nursing as a career path. Hospice nursing is not generally perceived, among new nursing graduates, as a preferred career path, since -- in addition to being a home care provider -- a hospice nurse is dealing with dying patients every day, and that is not something that is very easy for a lot of people.

Dr. Cohen observed that, although current providers argue that more competition would create more competition for a limited pool of nurses, he was not aware of any needed project ever being denied on the grounds that the service was needed but the proposed provider would not be able to hire anyone to provide it. Applicants provide a plan for how they will recruit and hire staff, and if the Commission finds that the service to be needed, it approves the application. A bigger concern about hospice services, he said, is that they are underused. He did not believe that any staffing shortage provides in itself a rationale for Certificate of Need coverage of a health care service.

Chairman Nicolay observed that the debate was beginning to recycle key points, and suggested that Task Force members had enough information to make a decision. He called for a vote. Three members voted in favor of deregulating the hospice program from the CON regulations (Cohen, Kane, and Suldan). Nine members voted in favor of retaining the current regulation (Bedrick, Bonde, Cody, Holland, Hussein, Pinkner, Stefanides, Weglein, and Wilson), with three members abstaining (Blumberg, Brown, and Ginsburg). Chairman Nicolay thanked the Task Force members, as well as the members of the hospice community who had attended the meeting, and Ms. Bonde for her information and guidance in the discussion.

- **Coverage by CON Review: Ambulatory Surgery Services**

Chairman Nicolay moved to the next agenda item, the regulation of ambulatory surgical services by Certificate of Need. He noted that Dr. Larry Pinkner represents the Maryland Ambulatory Surgical Association on the Task Force.

Dr. Blumberg said that the staff briefing paper on this issue demonstrated to him that no easy or obvious answer exists to the question of Certificate of Need coverage for ambulatory surgical capacity, and also that the same inconsistency of regulatory oversight that he has cited in other services also affects ambulatory surgery. Data in the briefing paper show that Maryland has the highest number of Medicare-certified ambulatory surgery centers in the country. These freestanding outlets are not subject to the rate-setting authority of the Health Services Cost Review Commission, as are Maryland hospitals, and therefore are more attractive to payers in search of lower costs and discount arrangements. An incentive exists for practicing physicians, receiving less per unit of service from payers, to maintain or increase their revenue by establishing office-based surgical capacity, thereby capturing the "facility fee" for procedures once performed in hospital outpatient settings. Dr. Blumberg emphasized that he did not know how to fix the system, but believes that there should be more uniformity in how we regulate the same service across its different settings of care. If the Task Force supports deregulating ambulatory surgery from Certificate of Need review, then rates for hospital outpatient procedures should also be removed from the authority of HSCRC, so that the settings of care are treated equally in that regard.

Dr. Cohen observed that HSCRC went to the General Assembly several years ago to propose deregulating rates for ambulatory surgery services at hospitals; Maryland hospitals opposed that change, and prevailed, thus continuing the inequality between hospital and freestanding ambulatory surgery settings in pricing and the ability to negotiate discounts with payers. Mr. Suldan described another inequality in the rate regulation of hospital-based ambulatory surgery, the so-called "awning test." This refers to a finding by HSCRC, historically requested by some hospitals, that their ambulatory surgical capacity is not "at the hospital" for rate setting purposes. This determination required that hospitals take measures to differentiate the outpatient surgical setting from the rest of the hospital buildings on the campus, such as different entrances (with separate awnings), different signage, and separate parking areas. Another irrational provision of the current regulatory structure results from the implicit distinction made in Commission statute (related to capital expenditures) between hospital outpatient and inpatient surgical capacity. He suggested that as the Task Force considers what should be regulated in a freestanding setting, the members must remember that the same rules that govern regulation of ambulatory surgery in the freestanding setting carry over into the hospitals.

Dr. Pinkner noted that he had provided to the members a written statement by MASA expanding upon its reasons for maintaining Certificate of Need coverage and the regulatory structure as they are. He agreed that the system is potentially confusing, since its underlying regulations and definitions have changed over the last nineteen years, including the last major change in 1995, when matters of medical specialty and group membership were removed from the law, and the number of operating rooms alone became the determining factor in Certificate of Need coverage. This had led to some providers establishing one operating room, and also multiple procedure rooms, which are not required to obtain CON approval, and using those "procedure rooms" as ORs. Dr. Pinkner said that once a surgi-center is approved and built, it is rarely inspected after its initial survey, because licensing staff is greatly overburdened. Dr. Pinkner did not know how many centers are using so-called procedure rooms as operating rooms, but repeated MASA's position that an important piece of

addressing this issue is to develop clearer definitions of, and distinctions between, operating and procedure rooms.

Dr. Pinkner said that three-fourths of the 26 states with Certificate of Need coverage of ambulatory surgical facilities also cover birthing centers and procedure rooms, and make no distinction between ORs and procedure rooms. Medicare reimbursement policies also cause problems in this area, by dictating that certain procedures must either be done in a physician office, because they are "too small" for a freestanding surgery center – or else at a hospital. Ambulatory surgical centers are contesting this policy at the national level. He acknowledged that Medicare does pay more for procedures it permits physicians to perform in an ASC than if the same procedure were done in a physician office setting.

Dr. Pinkner emphasized that he and his organization strongly support maintaining the one OR exemption from CON. In Maryland, most of the office-based single OR providers are plastic surgeons, podiatrists, and endoscopy centers. Only about 12 or 13 large, multi-specialty surgery centers exist in the whole state; many are wholly or partially owned by hospitals. He also noted that no one has ever applied for determination provided for under Commission statute that a center may add a second OR without Certificate of Need review, if necessary for "efficiency, safety, and quality" of the services offered. Ms. Barclay noted that the Commission has not promulgated regulations to implement that provision. She also said that the Commission has begun to receive an increasing number of Certificate of Need applications from one OR entities seeking to add a second operating room. This makes the center a health care facility, for Certificate of Need purposes, and subject to any regulation applicable to health care facilities under Commission statute.

Dr. Blumberg added anecdotal evidence regarding "perverse incentives" in Medicare reimbursement policy, which affect how and where surgical procedures are performed, but observed that these inconsistencies in the system – though they should be addressed -- are beyond the purview of the Task Force.

Chairman Nicolay asked Dr. Pinkner what he thought ought to be done, regarding the identified regulatory inconsistencies and definitional issues affecting this medical service. Dr. Pinkner responded with his personal view that doctors should be able to establish one operating room without Certificate of Need review, because reimbursement policies require them to perform many procedures in office settings, in order to receive payment. However, he believes that more than one room, in any specialty and of any configuration, should require Certificate of Need approval.

Task Force members discussed some of the definitional issues related to operating rooms versus procedure rooms. Ms. Barclay noted that, in its administration of determinations of non-coverage by Certificate of Need since the 1995 statutory change, the Commission has counted as an operating room any treatment space within a restricted sterile corridor. In recent years, staff has added questions about the size and specific physical features (ventilation, room surfaces, etc.) of rooms in existing centers, to understand more completely the nature and use of the outpatient surgical capacity in place around the state. No explicit definitions of the categories of surgical and treatment capacity exist currently in regulation.

Ms. Brown asked how many of the licensed ASCs in the Commission's inventory have more than one operating room, and if those centers were among those established under previous statute (in effect between 1986 and 1995) that permitted a physician or group practicing certain specified medical specialties and treating their own patients to establish up to four ORs. Ms. Barclay replied that most of the centers do not have more than one OR, and that most have one OR plus a number of procedure

rooms. In addition, the inventory also includes endoscopy centers with non-sterile procedure rooms and no operating rooms. Ms. Panek explained that, although these centers may seek and receive Medicare certification as an ambulatory surgery center for purposes of obtaining a facility fee, most are licensed as "freestanding endoscopy centers," a separate category of State license codified under the umbrella term "ambulatory care facilities" in licensure law.

Chairman Nicolay asked Dr. Pinkner if, as part of recommending that single OR entities remain not subject to Certificate of Need and that regulatory enforcement become more clear-cut, he also supported the elimination of the current administrative distinctions between a procedure room and the scope of procedures performed there, and the space and scope of what is considered an operating room. Dr. Pinkner replied that if even if current Certificate of Need coverage remains unchanged, the industry still needs better, clearer definitions of and distinctions between ORs and procedure rooms.

The Task Force continued to discuss the reimbursement incentives and policies that have contributed to the inconsistencies and irrationalities of the present regulatory framework. Ms. Brown observed that the State Health Plan does not have a need projection for ambulatory surgical services, and that may also have led physicians to find ways to evolve their practices by adding surgical capacity. Ms. Cody asked if there is a need methodology in the Plan; Ms. Barclay responded that one of the changes made to the Plan, after the changes to the definition of "ambulatory surgical facility" that permitted establishment of single ORs without Certificate of Need, was the removal of its need methodology. The Commission analyzes proposals to convert single OR entities into health care facilities by adding a second OR using the volume standards for optimal utilization still in the Plan.

Dr. Pinkner noted that it is difficult to identify need for ambulatory surgery, because every year more procedures move out of hospitals and into the freestanding setting because of both advances in surgical techniques and equipment and payer policies. In response to a question from Chairman Nicolay, Dr. Pinkner emphasized that single OR entities should be regulated, for reasons of patient safety and quality of care, but should continue to not require a Certificate of Need. Dr. Blumberg suggested -- because of the complexities of this issue, the need for more information, and the fact that so many factors affecting it result from reimbursement policies beyond its control -- that the Task Force not take a position, but instead refer the question of Certificate of Need coverage for ambulatory surgical services to the full Commission.

Dr. Pinkner asked that the Task Force confirm, if it decided to refer the issue to the full Commission, that it did not recommend deregulating ambulatory surgery from Certificate of Need coverage. Chairman Nicolay replied that he preferred to consider the issue in its entirety. Mr. Suldan stated that he was hesitant to defer to the full Commission on all aspects of the issue, suggesting a recommendation to the Commission that it regulate through Certificate of Need review only the establishment of new facilities, which, once established, could operate any number of operating rooms they wished.

Dr. Blumberg observed that if only 49 of 276 facilities had to undergo Certificate of Need review, then Certificate of Need in this area was not acting to constrain capital or payer costs or to link supply to need for new service capacity. He would support deregulation from Certificate of Need because of the incomplete and inconsistent nature of the current regulatory structure. He added that he could also support Dr. Pinkner's proposed tightening of regulatory control, which, if it exists, should be meaningful and consistently applied. He agreed with Chairman Nicolay's suggestion that the Task Force reconsider this issue in the context of additional information from Commission staff.

Commission Executive Director Rex W. Cowdry, M.D. expressed concern about the direction of the group's deliberations, given the short time frame in which the Task Force is to complete its work and forward recommendations to the Commission. It would be very difficult, in an issue area with the long and complex history as ambulatory surgery, for staff to present the Task Force with recommendations for action based on an appropriate level of analysis. The same holds true for the other coverage issues the Task Force has considered and on which it has taken preliminary actions. An analysis of specific coverage issues should include a careful analysis of the philosophical and economic bases for the CON. To reach a decision on whether to continue Certificate of Need coverage of hospice programs, for example, without examining the impact of Certificate of Need regulation on the number of hospice providers in the state over the last fifteen years, or the number of Marylanders served by hospice in relation to national averages over that period of time, is problematic.

What is needed, Dr. Cowdry emphasized, are ways to streamline the process of handling of CON applications. The Commission needs recommendations from the Task Force, as the users of this process, for ways that the staff can do its job better, smarter, and more efficiently within its existing resources, while protecting both the money that Marylanders pay out of pocket in insurance premiums and the quality of care that they receive in these facilities.

Dr. Wilson concurred with Dr. Cowdry, stating that he has been uncomfortable with the discussions and decisions on service-specific issues, and wanted to proceed to process issues. Mr. Kane agreed, adding that much of the public comment to the Task Force involved process issues, which are less controversial and on which Task Force members had a great deal of expertise. He expected that many of the proposals for streamlining the review process could be enacted without statutory change.

- **CON Review Process Issues: Interested Parties**

Chairman Nicolay began the discussion of potential changes to the Certificate of Need review process with the issue of interested party status, and presented a chart conveying key issues related to the discussion.

Ms. Barclay explained that this is the first of several CON review process issues identified in public comment presented to the Task Force, which included the definition of interested parties to CON review, completeness review of Certificate of Need applications and redocketing after significant changes to applications under review, and the capital review threshold for Certificate of Need coverage.

With regard to interested party status, CareFirst has proposed that Certificate of Need regulations be changed to provide that CareFirst is an automatically-designated interested party in all hospital projects involving capital expenditures of $25 million or more. One hospital system submitted comments suggesting that the definition against which interested party status is determined should be narrowed. Ms. Barclay noted that staff's briefing paper examines the changes over time in the definition of who qualifies to receive legal standing in CON review as an interested party.

Dr. Cowdry asked whether Task Force members understood the impact that a contested case with one or more designated interested parties has on the work of the Commission staff, on the Commission members, and on the review process itself. An understanding of that impact is crucial in this consideration, he explained, because this is a defining issue in the review process. A formally designated interested party – as opposed to the participation in a review by any member of the public, who can submit written comments for the Commission's consideration that will become part of the

record in a case – represents a threshold issue, in terms of increasing demands on already-constrained staff resources.

Ms. Barclay explained that in cases with a designated interested party, the Commission is required to appoint a Commissioner as reviewer, who is responsible for developing a recommended decision, issued in advance of the meeting at which the Commission will consider action on the CON application. An interested party may file a written exception to that decision, to which the applicant responds in writing, and both parties then argue those exceptions before the Commission prior to its final decision. In uncontested cases, Commission staff develops a report and recommendation that goes directly to the Commission for action. Interested parties may take a judicial appeal of the Commission's decision.

Dr. Blumberg asked if the Commission receives comments submitted by those without legal status as an interested party status for its review and consideration. Ms. Barclay replied that all comments and information received in the course of a review are reflected in the project analysis, but Commission members do not typically receive copies of the full text of those comments. Chairman Nicolay added that, in a contested matter, the Commissioner acting as reviewer does receive the entire written record of the case. Dr. Blumberg then asked if a group without formal interested party status that opposed the Commission's decision to approve a project that would affect its community would be prevented from appealing that decision in court.

Commission Assistant Attorney General Jason Sapsin replied that Commission statute provides interested parties with an explicit statutory right to appeal a Commission decision. Beyond that status and its attendant right, other legal mechanisms exist, such as due process considerations, which would also give a right of appeal. Mr. Sapsin said that, as counsel to a neighborhood or community group without interested party status that wanted to appeal a Commission decision, he would assert before the court a right of appeal, based on other considerations related to administrative law and constitutional due process.

Dr. Blumberg stated that, if any person or group has an ultimate right to appeal a Commission decision, he supported the elimination of interested party status altogether, as unnecessary to protect due process rights to appeal. Dr. Cohen strongly disagreed, noting that the burden of winning an appeal in court is much different from the burden of persuading the Commission to allow participation in the review process as an interested party. He asked the Task Force members to remember that the goal is to help get the best decision—not whether a party can get a court to say that the Commission acted in an arbitrary and capricious way, and that nothing in the record supports its decision.

Chairman Nicolay suggested that, in the decision whether to confer interested party status in a Certificate of Need review, the Commission needs to seek a balance between fairness and efficiency -- fairness, in getting everything in the record to consider in the CON case, and efficiency, in accomplishing the review in an appropriate time frame without unnecessary administrative requirements. Dr. Cohen continued to argue for the importance of the participation of interested parties in large and complex Certificate of Need reviews, and, specifically, for the importance of participation by CareFirst in projects involving the kinds of significant capital expenditures under review by the Commission, now and for the past several years.

Ms. Bonde observed that it is more difficult for someone with interest in an administrative proceeding, who is not a legally-qualified interested party, to successfully argue before a court to overturn an agency's decision.

Dr. Cohen argued that CareFirst should become an automatic interested party to reviews of large hospital capital projects, since – as the State's dominant third-party payer – it is directly affected by any decision that results in higher costs and potentially higher hospital charges. The current regulations require CareFirst or any other third-party payer to claim that a project will have a negative impact on the system, in order to gain status as an interested party. In practice, this means that when (as has happened) CareFirst wants to support a project, it may not become an interested party, with legal rights to re-enter a proceeding if the Commission approves changes to a project that CareFirst does not support.

Task Force member Christine Stefanides opposed expansion of the designated interested party definition, in the interest of keeping the process efficient. She has participated in a contested CON matter, and experienced the high resource requirement of a contested case, on both her hospital and the Commission and its staff. When the real "interest" of an interested party is to delay a project, or leverage a concession of some kind, that constitutes an abuse of this process. However, she concurred that legitimate interested parties need to have the right to participate, and suggested that some of the ideas proposed in the briefing paper for the tightening up of who is considered an interested party would help to avoid the kind of misuse of the system that adds unnecessary burdens and costs to the regulatory process.

Ms. Holland asked how many people submit written comments when they do not have interested party status. Ms. Barclay replied that in large CON cases, the Commission generally receives three types of comments: first, since local health departments receive copies of CON proposals, the Commission sometimes receives comments from those sources; second, the Commission receives comments from people in the community served or affected by the facility proposing a project; and, third, detailed written filings from persons or organizations seeking formal interested party status. Ms. Holland asked if many people file for interested party status. Ms. Barclay responded that most written comments do not include requests for interested party status. Mr. Suldan asked what percentage of CONs filed and approved are contested. In response, Ms. Barclay asked whether Mr. Suldan meant the percentage of cases that are contested and then approved subsequently or, the percentage of cases that are contested. She observed that because of the nature of some of the projects that the Commission is dealing with, including proposals for hospital projects, ambulatory surgery projects, and nursing homes, it has more contested cases than in the past.

Dr. Cohen pointed out that his comments specifically apply to hospitals, where CareFirst spends millions of dollars per year; and that the issue has nothing to do with hospices or home health agencies, from the standpoint of what CareFirst is saying. He reiterated that CareFirst should be part of the process. Mr. Kane asked how often CareFirst has been denied interested party status on projects for more than $25 million. Ms. Barclay deferred to Dr. Cohen, who said, once CareFirst learned that to get interested party status as a third party payer it had to challenge or oppose some aspect of a proposed project, it has qualified as an interested party. Ms. Barclay replied that the Commission follows the procedures set forth in statute and regulations, which require a Commissioner appointed as reviewer to make decisions on matters involving qualifications and challenges for interested party status. The determination is not made by the staff. Ms. Barclay suggested that one of the things that might be helpful for the Task Force to look at is whether that is the correct test.

Dr. Cohen thought that Ms. Barclay's point was an important one since, he said, a competing institution in the same market is entitled to interested party status, virtually automatically, because it may lose one customer and argue adverse effect. It does not have to be impacted significantly—it just has to provide the same service in the same community. In his opinion, a definition of "interested

party" that ignores millions of dollars' worth of impact on CareFirst unless it can demonstrate that the project will have a negative impact on the entire system does not make sense.

Dr. Bedrick suggested that the Task Force was dealing with two separate issues. Regarding the first, he urged the group to consider removing the regulatory requirement that interested parties must oppose a given project, and permit those making positive comments to have legal standing in a review. The second issue was CareFirst's insistence, as the major payer in the State, that it receive automatic interested party status in large hospital capital projects. Dr. Bedrick argued that to single out CareFirst among all other payers was inappropriate. Dr. Cohen replied that all third party payers have the right to be identified as designated interested parties for HSCRC reviews, though they do not participate.

Chairman Nicolay noted that CareFirst has requested automatic designation so that it does not have to make a filing in each proposed application. Dr. Cohen added that CareFirst is also seeking the recognition that a regulatory system works best when various sides are presented—not just the perspective of providers. Ms. Brown observed that the interest of payers in cost containment is not always consistent with the mission of the Commission to promote health care quality and access. Ms. Brown maintained that it would be inappropriate for the state to deem one payer as the designated interested party.

Commissioner Ginsburg called the question, citing two important considerations. He believes that the Commission should be a public process, and wants as many people involved in a decision as possible. As a Commissioner who participated in one of the most contentious of these interested party cases, his view was that the Commission wants to streamline the process. He cautioned that excluding people from the process is not the right way to accomplish this. He agreed with the position that entities submitting positive comments should also qualify for interested party status. The Commission, perhaps, should focus on how to include more people, rather than exclude them.

Chairman Nicolay replied that in the projects for which he has served as reviewer, the Commission received considerable informal written comment, which the recommended decision considered and incorporated. Ms. Brown added that any change in the definition of interested party process would require a regulatory change. Consequently, it would not be reasonable to change interested party status without looking at how a change in the definitional criteria would affect who can qualify as an interested party to a review. Potentially, a change might mean that more reviewers will be required, and the Commission is in need of more reviewers under current rules. Chairman Nicolay suggested, having listened to the Task Force members' opinions, that the Commission staff do further work on the definitional issue, and bring this back to the Task Force.

- **Completeness Review**

Chairman Nicolay said, on the issue of completeness review, that he had developed for the Task Force's consideration a proposal for substituting conferences for the current completeness review process. He recommended conferences composed of all of the parties at the completeness review level, for the purposes of meeting and discussing the issues, rather than corresponding back and forth by mail. He asked the Task Force members to review the proposed recommendation and defer further consideration of the issue to the next meeting of the Task Force. Ms. Barclay added that she had an earlier conversation with Douglas Wilson, Ph.D., whom, she noted, was unable to stay for the remainder of the meeting. Dr. Wilson questioned what time frames for the application review conference and project status conference would be. She indicated to him that the recommendation was a conceptual idea, though it would be possible to include time frames as a result of input from the Task Force members.

- **Capital Expenditure Review Threshold**

Ms. Barclay presented the briefing paper to the members present. Chairman Nicolay proposed that the Task Force consider the issue prior to adjournment for the day. Dr. Bedrick proposed that the threshold be modified to $7.5 million. Dr. Blumberg suggested that the modification should be $7.5 million with an index to inflation. Other Task Force members suggested that the threshold be set at $10 million. Chairman Nicolay noted that the threshold was currently $1.65 million, adjusted by the CPI. Years ago, the threshold was set for $1.25 million and has been adjusted up. He referred the Task Force members to the briefing paper and asked Ms. Barclay to discuss the issue.

Ms. Barclay said that staff had put together some data looking historically at the capital review threshold projects. For hospitals, a very small number of projects would be impacted at the levels under consideration because most hospitals, for the smaller capital projects, are taking the pledge and not going through the CON process. The data suggests that increasing the threshold would not really materially affect the number of projects that would be coming to the Commission because only a few projects have such a low capital threshold. With regard to nursing homes and some of the other projects, the status is a little less clear. Some of the nursing home projects that the Commission now reviews would not come to the Commission if the capital threshold were raised to $10 million. These would be, principally, renovation projects and not projects that would trigger other reasons for CON.

In response to a question from Chairman Nicolay about the effect on hospice services, Ms. Barclay replied that a new hospice requires a CON regardless of the capital threshold. Ms. Bonde said that to her knowledge, none of freestanding hospice buildings have been subject to CON separately from the hospice operational CON regulations. Ms. Panek clarified that Hospice of Baltimore, a GBMC affiliate that operates Gilchrist House, an inpatient hospice facility, did obtain a CON as part of its application to establish a general hospice program serving Baltimore County and contiguous Central Maryland jurisdictions. Joseph Richey House in Baltimore obtained a CON to establish its inpatient hospice facility in the 1970s, because Certificate of Need statute at the time included hospice coverage but did not distinguish between facilities and home-based hospice. In 1987, the General Assembly enacted statutory provisions that separated hospice licensure standards from those of home health agencies, and clarified that all hospice programs required a Maryland license. General hospice programs that wish to construct a residential site need a determination of Certificate of Need coverage for the related capital expenditure, not for the residential setting itself, since statute does not provide for separate licensure of residential or inpatient hospice beds or facilities.

Dr. Pinkner asked if a proposed surgi-center with one OR cost more than the threshold amount, would an applicant then have to get a CON? Ms. Barclay replied that for a one OR facility, a CON would not be required because it would not be a health care facility subject to CON review. A one OR facility is exempt from CON review, regardless of the capital expenditure level. Dr. Pinkner asked if the capital expenditure threshold only affects hospitals and nursing homes. Ms. Barclay responded that it would affect anything that is defined as a health care facility under the Commission's statute, including home health, hospice, acute care hospitals, nursing homes, residential treatment centers, and some kinds of non-hospital, non-acute care projects. The threshold also could apply to an ambulatory surgery facility that is a CON project, meaning that it has two or more ORs. The two related issues are, (1) should the Commission continue to index the threshold, as raised by Dr. Blumberg and in the comments received; and (2) should there be a separate threshold for nursing homes versus hospitals? Chairman Nicolay added, and (3) how much should it be?

Dr. Cohen proposed that the hospital threshold be $10 million, indexed by the Consumer Price Index (CPI). He declined to make a recommendation for nursing homes. Ms. Holland recommended $10 million for nursing homes, pointing out that this would enable a very aging group of facilities to

renovate more quickly and easily. Mr. Suldan said that when hospitals are taking the pledge, which is what the vast majority of these transactions were about, the outcome is largely known from the beginning. In his view, the only question is how much back and forth will there be with Commission staff, and how much time it will take for people who are preparing the letters, and people who are reviewing the letters. In his opinion, it makes sense to reduce the number of letters that have to go in, which would be accomplished by raising the threshold. He also suggested creating a standardized format for seeking approval of non-coverage when hospitals take the pledge. Ms. Barclay took issue with the statement that the outcome of projects proposed under the pledge is always known and always positive, but agreed with Mr. Suldan's suggestion for a standardized format, adding that the staff would prefer to get a more standardized filing because we struggle in understanding and analyzing the information that different hospitals file because that information varies greatly.

Dr. Blumberg supported Ms. Holland's suggestion for including the nursing homes in the $10 million proposed threshold. In consideration of the Task Force's earlier deliberations regarding nursing homes, he suggested that if the Commission can allow them to function and they want to stay in business, the regulations should be encouraging them to stay in business and upgrade their facilities. Mr. Kane agreed with Dr. Blumberg, as did Dr. Cohen, who suggested changing the inflation index to the Engineering News Record. Chairman Nicolay asked the inflation index in the Engineering News Record varies that much from the CPI. Dr. Cohen replied that it is considerably higher than the CPI because the CPI is Medicare's index for measuring what is happening to capital costs over time, taking into account the fact that capital costs at any one time are a blend of historical capital costs; whereas, the Engineering News Record calculates what is happening to the cost of construction moving forward.

Commissioner Ginsburg asked how much the proposed change would affect the Commission's work because, in his view, the Commission should separate the hospitals from the nursing homes. Chairman Nicolay suggested $7.5 million for the nursing homes and $10 million for the hospitals. Ms. Holland reiterated her proposal for a threshold of $10 million for the nursing homes. Commissioner Ginsburg suggested $5 million for nursing homes because there are many projects that will go under the Commission's radar. Ms. Holland clarified that nursing homes would not be able to change sites or capacity under her proposal. The capital expenditure threshold would only apply to on-site projects for renovation. If a nursing home wanted to change capacity, or add a service, or move, it would continue to be required to apply for a CON. Ms. Barclay confirmed that Ms. Holland was correct in her assessment.

Dr. Cohen noted that Medicaid has its own capital formula, so the proposed change is not likely to generate additional payments to nursing homes. In his opinion, if nursing home operators want to spend their money, that should be fine, and the $10 million threshold made sense. He made a motion that the capital threshold for all services be $10 million, for 2005 dollars, indexed by the Engineering News Record methodology currently in use by the CON staff. This motion was seconded by Dr. Blumberg. Task force members Bedrick, Blumberg, Bonde, Cody, Cohen, Ginsburg, Holland, Hussein, Kane, Pinkner, Stefanides, Suldan, and Weglein voted in favor of the motion, and Ms. Brown abstained from voting.

4. <u>Other Business</u>

There was no other business considered by the Task Force.

5. <u>Adjournment</u>

Chairman Nicolay announced that the next meeting would be held on Thursday, August 25, 2005 at 1:00 p.m. Commissioner Larry Ginsburg made a motion to adjourn, which was seconded by Ms. Bonde. The Task Force meeting was adjourned at 3:57 p.m.